New England Deaconess Hospital

pulse

185 Pilgrim Road, Boston, Massachusetts | Volume 37 — Number 2 | March/April, 1984

Computer system streamlines laboratory operations

A few years ago, the clinical pathology laboratory faced a serious problem. The volume of lab work was steadily increasing — as much as 20 percent each year — with no increase in staff. It was not just a problem of getting the work done; communication of requests for tests, inquiries into specimen status, and reporting of test results were becoming more and more difficult. "We couldn't handle the amount of data we were generating," says Charles Arkin, M.D., chief of clinical pathology. "It was taking hours for completed test results to be returned to the requesting physician."

The system was also bogged down in complicated paperwork. "Unit secretaries at the nursing stations had to use more than 20 different forms to request lab tests," says Joanne Casella, chief medical technologist. "For example, there were four different forms for chemistry tests, three for hematology; and the secretaries had to keep them all straight. If someone called to check on the status of a test specimen, it could take up to 10 minutes to go through the requisition forms and log sheets manually and find exactly where the specimen was."

Today, secretaries and nurses can order most tests without handling a single form and determine specimen status without as much as a phone call. Test results are available within minutes of the tests' being completed. The entire system of ordering, collecting, and processing lab tests has been streamlined by the new laboratory computer system, which is in direct communication with the hospital-wide ODISY patient information system.

When a physician orders a test at a nursing station, the unit secretary can transmit the order to the lab — including patient name, the type of test needed, and when the specimen should be collected — simply by touching the ODISY terminal screen with a special light pen. Medical technologists are scheduled to collect specimens at particular times each day, and an hour before they leave the laboratory control center in the Meissner building, the computer generates the test requests. Lists of the specimens to be drawn are printed out, as are labels for the specimen

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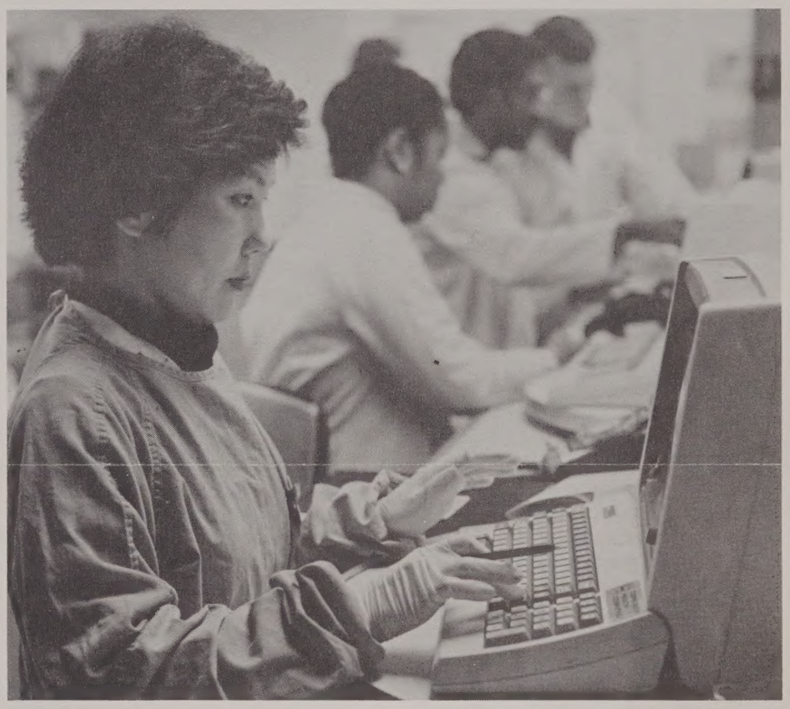


In the laboratory control center, Eileen Kim, medical technologist, enters test orders into the lab computer system.

Radiotherapist Tyvin Rich, M.D., (left) and surgeon Albert Bothe, M.D., position radiation cone before administering intraoperative radiotherapy.

Deaconess, Children's Hospital join forces for special radiation treatment

The Deaconess does not often have the opportunity to care for children. But because of a special treatment offered here, a six-year-old patient from The Children's Hospital has been given an improved chance for recovery from an unusual and complicated form of cancer. Rachel Buckowski of Easthampton, Massachusetts, came to the Deaconess in January for intraoperative radiotherapy, a radiation therapy treatment given directly to the tumor site during surgery. NEDH is one of only a few hospitals offering this treatment and currently the only one in the United States with a radiation therapy facility in a standard surgical suite.

Rachel had developed Wilm's tumor, a cancer of the kidney, at the age of four; and doctors at Bay State Medical Center in Springfield removed her right kidney. When a second tumor developed on her left kidney last year (a relatively rare occurrence), Rachel was referred to The Children's Hospital in Boston, where doctors prescribed a course of chemotherapy and conventional radiation treatment in an effort to save her remaining kidney. At first the treatment was successful, and the tumor vanished. But nine months later, a checkup revealed the tumor had reappeared.

Radiotherapist Tyvin Rich, M.D., who directs the NEDH intraoperative radiotherapy program, has worked with physicians at Children's through the Joint Center for Radiation Therapy. He explains that the recurrence of Rachel's tumor presented her doctors with a limited number of treatment options.

"There is a threshold radiation dose for the kidney," says Rich, "and if that dose is exceeded, you risk permanently damaging the kidney. Rachel had already received that level of radiation. To avoid having to remove her remaining kidney and placing her on dialysis, it was decided to remove only the portion of her kidney containing the tumor. We

(continued on page 5)

tubes; the labels indicate patient name, room number, time of collection, and the type of collection tube.

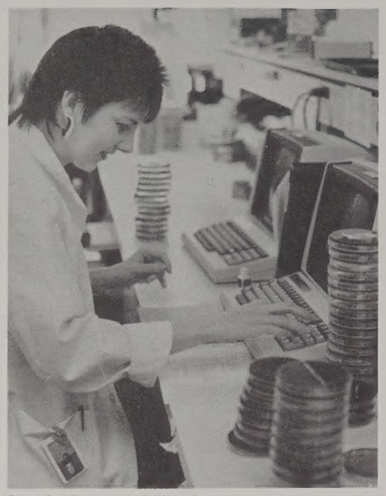
"Some of the tubes already contain additives needed for the test to be done properly, and the tubes are color coded as to content," says Casella. "The computer also prints 'aliquot' labels for tubes that will be needed in the lab during the tests, which is a real time saver."

"We do still use manual requisitions for tests that are collected by doctors and nurses or for tests requested less than an hour before the scheduled collection time," says Casella, "but now there are only two requisition forms, instead of 25."

When the technologists return to the control center after collecting specimens, they verify the collections on terminals in the center. If a particular specimen could not be obtained — the patient may have been out of the room or have refused the test — this is also indicated along with the reason. Specimens collected with a manual requisition are also entered into the system. Once the collections have been verified, inquiries regarding specimen status can be made through the ODISY system.

Most of the high volume testing instruments in the laboratories directly interface with the lab computer, and those test results are entered automatically into the system. Other test results are entered manually by the medical technologists, using terminals located throughout the labs. Every test result is displayed and verified by a technologist who looks for possible errors or inconsistencies.

Once a test result is verified, it is accessible via the ODISY system. Printed ward reports — test results for all patients on a nursing unit — are generated and posted three times a day, and a cumulative summary on each patient is printed and placed into the chart every morning.



Quatie Bryan, medical technologist, enters final reports in the microbiology lab.

Ann Ruggiero, who oversees the control center and the entire computer operation, says "We are delighted with the system. We are responsible for coordinating all test requests, tracking specimens, and reporting results. Before, it was very difficult and frustrating, because we had outgrown our ability to respond to requests for information. The computer has greatly enhanced our ability to respond to the needs of people who use the lab."

"The lab computer went live in July, and we interfaced with the main ODISY system in November," says Casella. "The acceptance by the laboratory staff has been terrific. Some of the physicians have suggested improvements to the report formats, and we have been working with them to fine tune the system and incorporate those suggestions that will make it more user friendly."

"Many of the lab computer systems installed in hospitals over the past 10 years have failed," says Arkin, "so we made sure to choose a system and a company with a good track record in serving the complex needs of a hospital like the Deaconess. We did a thorough analysis of our needs and surveyed other hospitals with similar systems. Gene Gallagher [director of data processing] was very helpful to us all along. We didn't know anything about computers when we began, and he guided us and provided invaluable advice."

The team effort that went into setting up the system is a major reason for its success. The committee responsible for the lab computer worked closely with people from data processing, and the team overseeing the ODISY system. People at all levels of the laboratories contributed to the analysis of the system's needs, and other users of ODISY were in regular communication with the laboratory team.

"Everyone worked very hard to make this system work, and we have had very few problems," says Arkin. "Joanne has been involved in the project since the original systems analysis, and Ann has done an amazing job in the control center, which is really the backbone of the system. The supervisors and other members of the laboratory computer team devoted hours to learning the system and teaching the other users. They've helped to motivate everyone — it's really the people who've made the system work."

Mary Buckley, Farr 3 unit secretary, orders a lab test by touching her ODISY terminal screen with a light pen.

Deaconess continues long-time anti-smoking effort

At a January news conference marking the 20th anniversary of the surgeon general's report linking cigarette smoking and cancer, Massachusetts Commissioner of Public Health Bailus Walker Jr. called for a uniform policy on smoking in the state's health care facilities. The Deaconess is one of many Massachusetts hospitals that has limited smoking for a number of years and has worked to educate patients and employees on the dangers of smoking.

"A lot of hospitals are doing an excellent job with smoking," says Blake Cady, M.D., surgical oncologist and chairman of the NEDH Smoking Policy Committee. "We all use New England Memorial Hospital in Stoneham as an example — there is no smoking allowed there at all. Many other hospitals have policies that were based on ours, which was one of the first in the state.

"On the other hand, there are still institutions where you can walk in and see people smoking in the front lobby," Cady says. "It's ironic that an organization which may be working to treat or cure cancer doesn't pay attention to such simple, practical measures."

The Deaconess smoking policy prohibits smoking, except in a few designated areas. Patients may not smoke unless they have specific permisson from their physician. Employees may smoke only on their free time and then only in designated lounges or the "Pilgrim's Korner" vending area in the Baker Basement. Visitors are asked not to smoke in the hospital.

Some of the special care patient floors — such as Farr 3, Farr 8, and the Farr 6 intensive care floor — are completely smoke-free. On some other floors, nurses have voted to make their lounges "no smoking" areas.

"Current public attitude surveys show that most smokers, as well as non-smokers, agree that smoking should be limited," says Cady.

Education and support for those trying to quit smoking are important concerns of the Smoking Policy Committee. Cady says, "It's been documented that smoking is a very powerful addiction — it's the most common addiction in the world. We realize that it's very hard to stop smoking. Women find it particularly difficult to quit, for reasons we don't understand yet, and lung cancer is about to surpass breast cancer as the number one cancer killer of women."

The Deaconess has a long history of activity related to smoking and health, including the work of Richard Overholt, M.D., founder of the Overholt Thoracic Clinic and a pioneer in developing the connection between smoking and disease. Smoking restrictions at the Deaconess began in the early 1960s and expanded until the hospital's smoking policy was formalized in 1977. At that time less than 5 percent of the nation's hospitals had anti-smoking efforts. In addition, for the past few years, the hospital has hosted the Massachusetts chapter of GASP (Group Against Smoking Pollution), an organization working to further the rights of non-smokers.

"Over the years we've had a lot of very dedicated people involved in this effort," Cady says, "from Dr. Overholt and the late Dr. Theodore Badger, through Dr. Joseph Andrews who was the first head of the Smoking Policy Committee, to the many people who are working on it today — Peter Campisano in Administration, Ellen Leary in Nursing, and doctors Peter Maggs, Richard Rose, and Ron Silvestri. I think the Deaconess has been able to accomplish so much because of this special group of people."

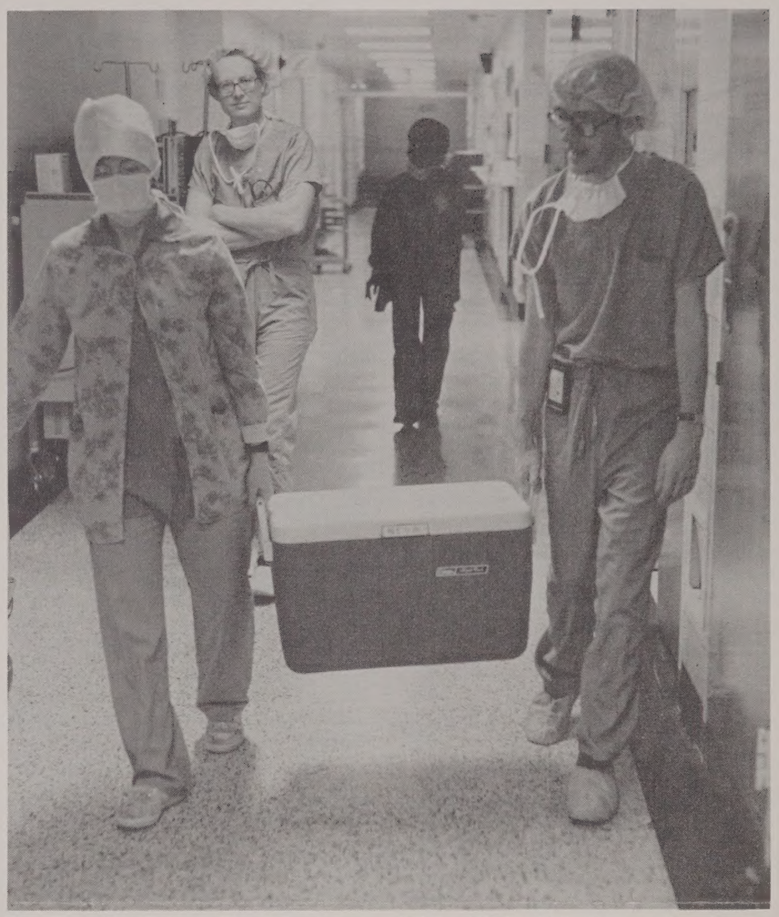
State, Blue Cross decisions clear the way for liver transplant program

On January 24, the Massachusetts Public Health Council approved the proposal of four Boston hospitals — the Deaconess, The Children's Hospital, Massachusetts General Hospital, and New England Medical Center — to establish the Boston Center for Liver Transplantation (BCLT). The following week, Massachusetts Blue Cross/Blue Shield announced its decision to classify liver transplants — along with heart and heart-lung transplants — as a generally accepted medical procedure. By removing many of the regulatory and financial obstacles to liver transplantation, these decisions enabled the Deaconess to begin a planned, controlled liver transplant program in conjunction with the other BCLT members.

Before this decision, liver transplants could be done in Massachusetts only through a waiver from the Department of Public Health. Waivers were granted only in case of emergency — if a patient's life was in immediate danger. Liver transplant surgeon Roger Jenkins, M.D., says, "We were dealing with a patient group that was so sick, they had a chance of survival of only 40 to 50 percent. Now we have more time to look for better liver donors, and most of the patients are not so sick that they must stay in the hospital until their transplant."

"Last year was very frustrating," says William V. McDermott, M.D., chairman of the Department of Surgery. "Our team of highly trained young surgeons was ready and equipped to embark on a program of liver transplantation, but we were limited to 'emergencies' by the regulators. I can understand the concern of planners with controlling costs and ensuring organized development of new programs. I would hope, however, that planners and providers of medical services work together rather than separately, since what we all want is the best care for the patients."

Anthony Monaco, M.D., head of transplantation, says that the approval of the BCLT is "a wonderful thing. Liver transplantation is an extremely difficult undertaking that can usurp not only the physical resources but also the intellectual and emotional resources of an institution if not controlled. The BCLT is an excellent example of how the scientific community can share the burden of such a major undertaking. I don't believe that this will cause any transplants to be done unnecessarily, as some people fear; it's simply too time- and resource-consuming a procedure."



Mary Bogosian, R.N., cardiac perfusion nurse, (left) and Walter Dzik, M.D., medical director of the blood bank, carry cooler containing a donor liver to an operating room.

Liver transplant surgeon Roger Jenkins, M.D., (right) prepares a donor liver for transplantation.

The interhospital cooperation that is central to the BCLT has actually existed since before the first NEDH transplant was performed in July, 1983. Relationships between personnel at all four hospitals are strong, and surgeons from the other hospitals are frequently involved in the transplants at the Deaconess. "I think it's great to do things that way, because we can share experiences," says Jenkins.

"We've really got our teamwork together here. People are now interested in gathering information on liver transplantation that could be of use to other programs in the country," Jenkins says. "We're planning to try some ideas that they simply don't have time to look at in Pittsburgh."

Monaco says, "A lot of people throughout the hospital — nursing, blood bank, infectious disease, immunology, anesthesia, and others — have come together to contribute to this effort. There's also a lot of interest in research in liver transplantation, and there aren't many centers doing it in this country."

McDermott points out that the program "will inevitably lead to observations, many of which may be unusual or unique, which could contribute to the advancement of knowledge in the complex area of liver physiology and biochemistry as well as in transplantation immunology."

As part of the Public Health Council decision on the BCLT, the participating hospitals have been allowed an increase in their maximum allowable cost under Chapter 372 of $40,000 per procedure. "This will allow us to add a little more staff for the program," says Peter Campisano, NEDH associate director, "although not as many as we need. Liver transplants will still lose money for the hospital. We are anticipating that we'll do 18 transplants in the coming year, and by planning and managing the program, we will try to keep that loss at a minimum."

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PULSE is published by the Public Relations Department, New England Deaconess Hospital, 185 Pilgrim Road, Boston, Massachusetts 02215, telephone (617) 732-8046. Third class postage paid in Holliston, Massachusetts. Permit (non-profit organization) No. 18.

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Corporation members gather for annual meeting

The annual meeting of the corporation of New England Deaconess Hospital was held on January 17 in Joslin Auditorium. Trustees, corporators, and administrators met to review the hospital's activities for fiscal year (FY) 1983 — the first full year of operation under Chapter 372, the Massachusetts hospital cost containment law — and to discuss aspects of the health care system that could affect NEDH in the years ahead.

Chairman of the Board Marvin G. Schorr presided over the business meeting: reports were given by Robert J. Spiller, chairman of the Audit Committee; William Tyler, chairman of the By-Laws and Nominating Committees; James F. Morgan, treasurer; Mary Eliza McDaniel, president of the Friends of the Deaconess; A. Richard Christlieb, M.D., chairman of the Medical Administrative Board (MAB); and Laurens MacLure, president.

Morgan said, "It was a very difficult year, but the hospital managed to show a gain from operations of $152,000." He said that both patient service and nonoperating revenue increased in FY 1983. Total admissions rose five percent, yet total patient days dropped, demonstrating the Deaconess medical staff's positive response to Chapter 372 cost control incentives.

Christlieb's report highlighted the accomplishments of the medical staff during the past year. The most significant development was the implementation of the liver transplantation program. The Pulmonary and Infectious Disease sections of the Department of Medicine were greatly expanded, as was the Department of Anaesthesia. In the Department of Pathology, the installation of a new computer system made lab results easier and faster to receive.

McDaniel presented Schorr with a check from the Friends of the Deaconess for $50,000 to be used in the renovation of the Farr lobby. The Friends raise money — through events such as the Christmas Bazaar, book and flower sales, and the Gift and Thrift Shops — to support a variety of projects, including School of Nursing scholarships and purchase of new equipment.

At the annual meeting (left to right), Marvin G. Schorr, chairman of the board of trustees; James F. Morgan, treasurer; and Laurens MacLure, president.

Said McDaniel, "I give you money, but with it I hope a cheerful spirit ever present around the hospital, reminding everyone that we are Friends who support education, research, and patient care."

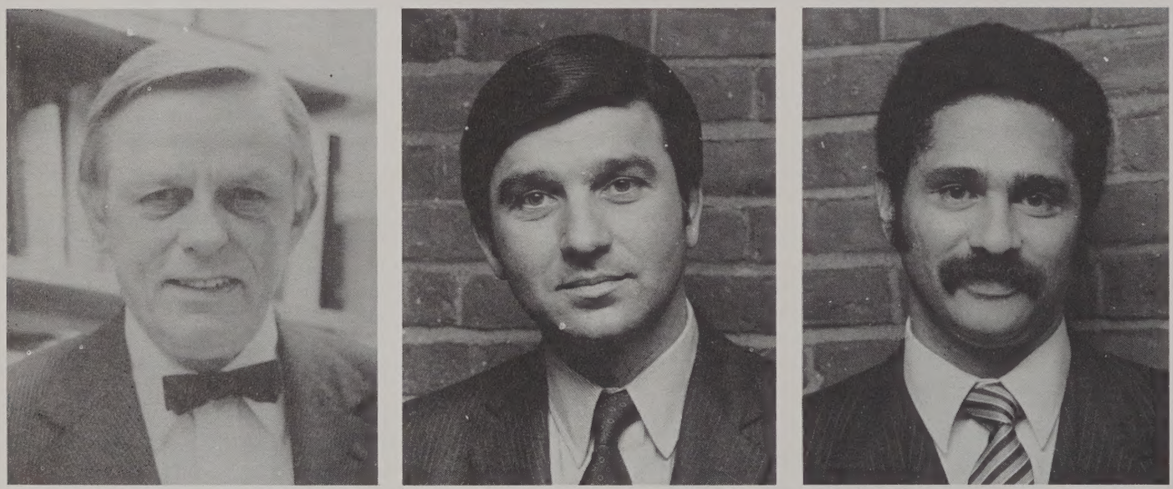
Deaconess welcomed new trustee Robert F. Bradley, M.D., and corporators F. Anthony Orbe and James M. Loveday at the annual meeting. John I. Carlson Jr. was elected vice chairman of the Board of Trustees, and Chairman Schorr and Vice Chairman Colby Hewitt Jr. were re-elected.

Special recognition was given to retiring trustee John F. Keane, president of Keane, Inc. Keane has been a corporator since 1972, a trustee since 1979, and has served continuously on the Audit Committee. He will remain a member of the corporation.

In his address to the corporation members, MacLure outlined some of the changes occurring in the health care industry. Health maintenance organizations, including Harvard Community Health Plan and Bay State HMO — which hospitalize fewer patients for significantly fewer days than patients with other types of health insurance plans — are expanding. Preferred provider organizations, seeking the lowest cost hospitals to care for their insureds, are being organized in the state. And the "for profits" or investor-owned hospital chains now are beginning to appear in New England.

MacLure said, "The nation's health care system is undergoing inevitable change. We do not plan to become obsolete or incompatible with the environment of the future. At the same time, we are determined not to lose sight of our primary mission to provide the highest quality of patient care to those who come to the Deaconess for help."

NEDH welcomes new trustee, corporation members



Elected at the 1984 annual meeting were new trustee Robert F. Bradley, M.D., (left) and new members of the corporation James M. Loveday (center) and F. Anthony Orbe.

New trustee Robert F. Bradley, M.D., president of the Joslin Diabetes Center, Inc., has been a Deaconess corporation member since 1974. A director of the Controlled Risk Insurance Co., Inc., he also serves on the board of directors of the Medical Area Services Corporation. Section Chief of Endocrinology at NEDH, Bradley also holds staff appointments at Joslin Diabetes Center and Brigham and Women's Hospital. He is an associate clinical professor of medicine at Harvard Medical School and a member of several professional societies, including the American College of Physicians, the American Diabetes Association, and the Massachusetts Society of Internal Medicine.

Corporator James M. Loveday is vice president of securities sales for Goldman, Sachs & Company in Boston. He is the former consultant to the Massachusetts state legislature's Joint Committee on Post Audit and Oversight and served as director of the Federal Grant Clearinghouse of the state's Executive Office for Administration and Finance. Loveday is a member of the Boston Securities Traders Association and the Harvard Business School Association of Boston, and serves on the board of directors of the Brockton Industrial Development and Financing Authority.

Corporator F. Anthony Orbe is assistant vice president of Metropolitan Life Insurance Company's New England Regional Office of Real Estate Investments. President of the New England chapter of the National Association of Industrial and Office Parks, Orbe also is a member of the International Council of Shopping Centers, the Greater Boston Real Estate Board, and the Massachusetts Designer Selection Board.

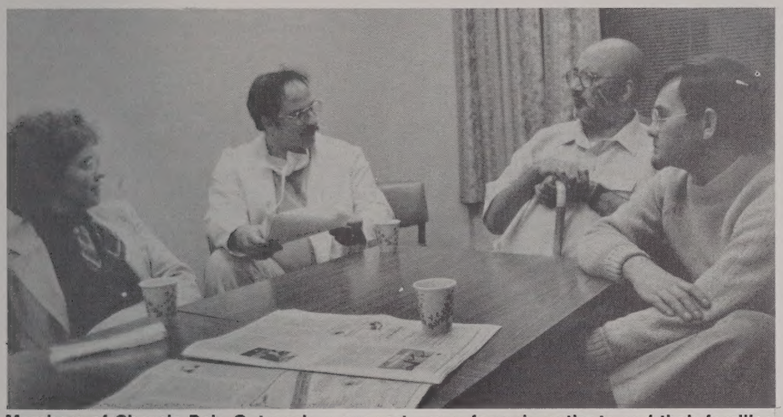
Helping those with chronic pain

For most people, pain is an unpleasant interruption of daily living; but whether pain is mild or severe, it eventually ends. For those with chronic pain, however, there is no end. The pain continues.

Any painful disorder that persists longer than six months is considered chronic pain. There are many types of chronic pain — recurring headaches, post-injury low back pain, pain associated with neurologic injury or diseases such as diabetes or cancer, and pain caused by inflammatory changes like arthritis or muscular disorders. Chronic pain has very strong physical and emotional effects on the individual and may severely restrict the quality of life.

Jeff Tyler, a chronic pain patient at the Deaconess for eight years and co-founder of a chronic pain support group meeting at the hospital, says, "My pain varies from being a minimal annoyance to being totally incapacitating. When I'm in pain, I don't want people around, and I don't want to be around people. I just want to lay in bed and stay there."

To help patients deal more effectively with the physical and emotional effects of chronic pain, NEDH physician Melvin J. Krant, M.D., conducts a weekly pain clinic for ambulatory patients with chronic pain syndromes. Says Krant, "The pain clinic will, I hope, help people deal with life more effectively. We want to provide a better life for them — to get them back into the job market, back into a work orientation, basically back into a much more comfortable relationship with life."



Members of Chronic Pain Outreach, a support group for pain patients and their families, (left to right) Caroline Dyer-Gunn; Richard Pearl, M.D.; Mason Groves; and Jeff Tyler.

Patients are seen on Monday afternoons from 1 to 4 p.m. in the Chief Resident's Clinic. A team of physicians, nurses, and other health care workers treat the physical, emotional, psychological, behavioral, and, if necessary, the nursing aspects of long-term pain. Says Krant, "There is no single treatment package or formula applicable to everybody. Treatments are specifically tailored to the individual."

Treatments can include a behavioral medicine component dealing with relaxation techniques, hypnosis, biofeedback, and acupuncture. A neurostimulatory unit is being developed which involves the application of currents of electrical stimulation to various parts of the central nervous system. A biochemical study will look at the depletion of certain materials in the brain that may allow the sensation of pain to become overwhelming. Physicians also will examine a number of phenomena associated with depressional relationships to pain.

Says Valerie Pearl, a chronic pain patient, "There are times when I get very depressed and can't cope very well. During those times, my greatest problem is just day-to-day life — making myself go on knowing tomorrow I'll hurt too."

To assist chronic pain sufferers and their families in coping with the emotional as well as physical stress often associated with chronic pain, the hospital provides space for a patient-to-patient support group founded by Pearl and Tyler. A local chapter of Chronic Pain Outreach — a nationwide network of chronic pain sufferers — the group not only provides support, but also tries to foster a realistic understanding for patients and their families of the various facets of chronic pain. The group functions on the same premise as Alcoholics Anonymous — that by talking and sharing, people can help one another over the rough times.

Says Pearl, "The group is what it says it is — a support. As you listen to other people and their experiences and how they cope with this problem or that problem related to the pain, you can learn something to help you — something you can take and utilize in your own life. It's very helpful."

Treatment of the physical and support of the emotional problems

(continued on page 6)

Radiation therapy *(continued from page 1)*

felt that the intraoperative radiotherapy could help to eradicate any remaining disease without damage to the healthy portion of her kidney."

Rachel's mother Eileen Buckowski says, "Having the extra option of the intraoperative radiotherapy was very important to us. We knew there could be no more regular radiation treatment, and we were afraid of the tumor coming back. Dr. Rich was terrific — he took the time to explain the procedure and the possible risks, and we decided it was a chance we wanted to take."

A team of Children's Hospital surgeons, nurses, and anesthesiologists participated in the procedure. "It was the first time we treated a child of that age," says Rich, "and we needed their expertise. They brought their specialized instruments and knowledge of the subtleties of pediatric surgery and anesthesia. We provided the space, the equipment, and our skill with the intraoperative radiotherapy procedure."

Alan Retik, M.D., chief of urology at Children's, removed the tumor from Rachel's kidney; then Rich and Deaconess surgeon Albert Bothe, M.D., prepared her for the radiation therapy. A special lead-lined radiation cone was positioned against the tumor site in such a way as to shield the rest of the kidney and other sensitive tissues from the radiation. The radiation machine was moved into position and "docked" with the cone, and then the entire team moved into an observation room adjacent to the operating room. Throughout the radiation treatment, the anesthesiologists directly monitored Rachel's vital signs, watching through a leaded glass window and using a duplicate set of equipment in the observation room.

Rachel is the 44th patient to receive intraoperative radiotherapy at the Deaconess since the program began in 1981. Although Rich cautions that the hospital's experience is still preliminary, the overall results of the program are encouraging. "We have seen improvement in the palliation of patients with pancreatic cancer, and we have a group of advanced colorectal cancer patients that appears to be doing quite well," he says.

"One of the things we have to watch for with a procedure like this is unacceptable toxicity to the healthy tissues underneath the tumor," Rich says. "So far, it appears that intraoperative radiotherapy is a feasible procedure which is not associated with serious acute or long-term toxicity. Our information, along with the data from other centers in the United States, supports the idea that giving a higher dose of radiation, while excluding normal tissues, can result in improved local tumor control without increased complications."

Six-year-old Rachel Buckowski, shown here with Children's Hospital nurse Cyndi Stoltzfus, R.N., received intraoperative radiotherapy at NEDH.

Although it is too soon to evaluate the results of intraoperative radiotherapy for Rachel, both her doctors at Children's and the Deaconess staff involved in her treatment agree that all aspects of the procedure went well and that her outlook is very positive.

"Nothing could be better," says Rich, "than knowing we have had success with a case that is usually very difficult to control. If we can demonstrate that intraoperative radiotherapy is an effective way of treating children with Wilm's tumor, while exposing less normal tissue to the effects of radiation, there may be many potential benefits for these children."

Chronic pain *(continued from page 5)*

associated with chronic pain are part of the hospital's commitment to pain patients, which also will include pain research. Says Krant, "There are several pain centers in the U.S. What will make ours different is that it will not only involve the administration of various kinds of known remedies but also will be associated with basic scientific investigation."

Some research will examine what constitutes pain disorders; other projects will study how the central nervous system, the brain, and the spinal cord work, and how this working relates to the specific problems patients have. Clinic patients will play a significant role in the research programs in which the long-term goal is not just the treatment but also the elimination of chronic pain. Says Tyler, "Research into pain is embryonic. Real help is still a long way off, but at least there's a hope that they may discover the causes and perhaps a cure for pain. Sometimes that hope is what gets me through the day."

Moving? We'd like to know.

Because the post office does not forward third-class mail, we need your help in keeping the PULSE mailing list accurate. If you are moving, please inform the NEDH Public Relations Department, 185 Pilgrim Road, Boston, Massachusetts 02215, (617) 732-8046. It would be particularly helpful if you could send your PULSE address label. (NEDH employees should inform their supervisors of changes of address.) Also let us know if you receive more than one copy of PULSE.

News in Brief

Mian M. Ashraf, M.D., thoracic surgeon, recently presented lectures on the surgical treatment of coronary artery disease to the Eighth Saudi Medical Conference in Riyadh, Saudi Arabia and the International Congress on Cardio-Pulmonary Diseases in Calcutta, India.

Nutritional Support Services published a paper on home total parenteral nutrition by **Richard Baptista, M.S., R.Ph.,** clinical hyperalimentation pharmacist. Baptista also presented an abstract on selenium deficiency to the American Society of Parenteral and Enteral Nutrition Clinical Conference in January. The abstract was published in the *Journal of Parenteral and Enteral Nutrition.*

The Diploma Nurses Association held a meeting on Alzheimer's Disease at the NEDH School of Nursing (SON) on February 9. Among the participants were **Marcia Benser, R.N., M.S.,** instructor, SON; and **Ernie Cakounes,** media specialist, SON.

Murray Bern, M.D., hematologist, presented papers on low-dose warfarin therapy to the American Society of Hematology and the American Society of Parenteral and Enteral Nutrition. The papers were co-authored by **Bruce Bistrian, M.D.; Albert Bothe, M.D.; Charlotte Champagne, R.N.,** and **Mary Keane, R.N.**

The Massachusetts Public Health Association presented its Lemuel Shattuck Award to **Blake Cady, M.D.,** surgical oncologist, for his leadership in the effort to control cigarette smoking.

In January, **John Chaffey, M.D.,** chief of radiation therapy, spent three days as visiting professor of radiation therapy at the University of Virginia.

Mary L. Christie, R.D., M.S., clinical dietitian specialist in gastroenterology, recently spoke to the national meeting of the American Society of Enteral and Parenteral Nutrition and to a meeting of the National Ileitis and Colitis Association.

Frank Condella, R.Ph., assistant manager, pharmacy/I.V. therapy, spoke to the midyear clinical meeting of the American Society of Hospital Pharmacists (ASPH) on the NEDH system of compounding parenteral nutrition solutions. **Paul Sesin, R.Ph., Pharm. D.,** coordinator of the clinical pharmacy, also spoke to the ASPH meeting, presenting a paper on DRG's and the hospital pharmacy. **E. Gaj,** staff pharmacist, collaborated with Sesin on a paper on the growth of micro-organisms in dexorubicin and floxuridine media, published in *Particulate and Micro Control.*

F. Henry Ellis Jr., M.D., chief of thoracic surgery, presented a paper on reflux control by fundoplication and moderated a breakfast session on esophagomyotomy at the annual meeting of the Society of Thoracic Surgeons in January.

Susan Forti, senior staff engineer, spoke to the annual systems conference of the Hospital Management Systems Society of the American Hospital Association on developing a hospital information center.

Janis Gallagher, coordinator of I.V. therapy, has been chosen president-elect of the New England Chapter of the National Intravenous Therapy Association.

Jack Hawiger, M.D., chief of experimental medicine, has been appointed a member of the hematology study section for the National Institutes of Health. He has recently spoken to the platelet workshop at the annual meeting of the Japanese Biochemical Society in Fukuoka, Japan, and the Platelet Research League in Osaka, Japan. Hawiger also lectured on platelet receptors at Tokyo University.

Robert S. Lees, M.D., chief of peripheral vascular diseases, spoke on non-invasive cerebral blood flow at the Barrow Neurological Institute on Stroke at St. Joseph's Hospital and Medical Center, Scottsdale, Arizona.

Paul Kasulis, C.N.M.T., research associate in nuclear medicine, spoke to the national midwinter meeting of the Society of Nuclear Medicine on brain imaging with SPECT and radiolabeled amines.

Robert C. Moellering, M.D., chairman of the Department of Medicine, was visiting professor at the University of Geneva (Switzerland) Medical School in February.

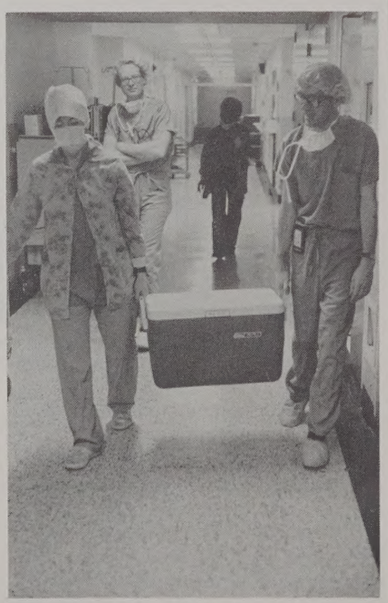
Barbara Moody, administrative assistant for budget and finance in the Department of Nursing, discussed nursing management information systems at the annual systems conference of the Hospital Mangement Systems Society of the American Hospital Association.

Tyvin Rich, M.D., radiotherapist, spoke on intraoperative radiotherapy at the M.D. Anderson Hospital in Houston, Texas, and at surgical grand rounds at Dartmouth Medical School, Hanover, New Hampshire.

Albert Sheffer, M.D., allergist, presented grand rounds on exercise-induced anaphylaxis at the Dartmouth Medical School.

Michael M. Wick, M.D., dermatologist, spoke at the Seiji Memorial Symposium in Tokyo and lectured on recent advances in treating malignant melanoma as visiting professor at the Tokyo Medical & Dental University.

State approves liver transplant program (see page 3)



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